DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-16

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/02

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.325

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $0
b. FFY 03 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B page 20.22

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
Targeted Case Management Service Payments.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mike Robinson

13. TYPED NAME: Mike Robinson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 9/30/02

16. RETURN TO:

Frances McGraw
Eligibility Policy Branch
Department for Medicaid Services
275 East Main Street 6W-C
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 30, 2002

18. DATE APPROVED:
December 24, 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Rhonda R. Cottrell

21. TYPED NAME:
Rhonda R. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

XXIII. Case Management Services

A. Targeted case management services for severely emotionally disturbed children and adults with chronic mental illness.

Providers are paid a uniform interim rate. The uniform interim rate approximates an average of provider actual costs from the previous year. Prior to July 1, 2002, the uniform interim rate was settled to individual provider actual cost at the end of the state's fiscal year. Providers are required to submit an independently audited cost report as acceptable documentation of actual cost.

The billable unit of service is one month.

For state fiscal year July 1, 2002 - June 30, 2003, the uniform interim rate will be the final rate, and will not be settled to provider actual cost.

B. Targeted case management services for children with developmental disabilities provided through an agreement with the Title V Agency.

Payments for case management services are on a per encounter or per item basis. Payments shall be based on documented costs for the direct provision of services. Documented costs do not include payment for administrative and indirect overhead costs of the Title V agency or its contractor state agency, the Department for Mental Health and Mental Retardation Services. The Title V Agency, (or its contractor state agency, the Department for Mental Health and Mental Retardation Services) must maintain, in auditable form, all records of expenditures for services for which claims of reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.